STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/21/2011	
	PROVIDER OR SUPPLIE TON MANOR HEA	R LTH AND REHABILITATION CEN	TER	5700 W	ADDRESS, CITY, STATE, ZIP CODE VILKIE DR NAYNE, IN 46804		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	Complaint IN00		F00	00			
	•	1101272-Substantiated,					
		ficiencies related to the					
	allegations						
		7, F 282, F 314 and F					
	309.						
	Survey dates: D	December 19, 20, and 21,					
	Facility number	: 000476					
	Provider numbe	r: 155446					
	AIM number:	100290870					
	Survey team:						
	Diane Nilson, R	N TC					
	Carol Miller, RN						
		•					
	Census Bed type	e·					
	SNF/NF: 134	. .					
	Total: 134						
	10141.						
	Census payor ty	ne·					
	Medicare: 11	r - ·					
	Medicaid: 84						
	Other: 39						
	Total: 134						
	10.001. 134						
	Sample: 3						
LABORATOR	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SIC	NATURI	3	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

M1VR11

Facility ID:

000476

PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155446	B. WIN			12/21/	ZUII
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
CO///NO		TH AND DELIADIRITATION CENT	TED		ILKIE DR		
		TH AND REHABILITATION CEN	IEK		VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE!		DATE
		es reflect state findings					
	cited in accordan	nce with 410 IAC 16.2.					
	0 11	1 . 110/00/11					
		ompleted 12/28/11					
	Cathy Emswiller	·KN					

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Event ID: M1VR11

Facility ID: 000476

If continuation sheet Page 2 of 53

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLI	ETED
		155446	B. WIN			12/21/2	2011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t e e e e e e e e e e e e e e e e e e e			ILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	TER		VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0157	483.10(b)(11)						
SS=D	NOTIFY OF CHA	ANGES					
	,	NE/ROOM, ETC)					
	•	nmediately inform the					
		with the resident's physician;					
		tify the resident's legal					
		r an interested family					
		nere is an accident involving characteristic characteristic characteristic characteristics.					
		requiring physician					
	•	gnificant change in the					
		al, mental, or psychosocial					
		terioration in health, mental,					
	•	status in either life					
	threatening cond						
		a need to alter treatment					
		, a need to discontinue an					
	•	reatment due to adverse					
		or to commence a new form					
		a decision to transfer or					
	_	sident from the facility as					
	specified in §483	5.12(a).					
		also promptly notify the					
		nown, the resident's legal					
	•	r interested family member					
		change in room or roommate					
	-	pecified in §483.15(e)(2); or					
		dent rights under Federal or ulations as specified in					
	paragraph (b)(1)	•					
		record and periodically					
		ess and phone number of the					
		epresentative or interested					
	family member. Based on intervie	ews and record reviews,	F01	57	1. The MD was notified of		01/20/2012
		I to ensure the Physician			change of condition on 11/24/11 fo	r I	-
		-			resident C. Resident D no longer		
	-	mptly when the residents			resides in the facility.		
	-	condition resulting in			All residents were reviewed		
	having to have su	urgery (Resident C) and			for changes in skin conditions with		

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Event ID: M1VR11

Facility ID: 000476

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155446	B. WIN			12/21/2011	
NAME OF A				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	C		5700 W	ILKIE DR		
COVING	TON MANOR HEA	LTH AND REHABILITATION CEN	ITER	FORT V	WAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ĺ
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
		loped a 2nd pressure			MD notification as appropriate.		
	•	ysician notification. This			3. Licensed nurses will be		
	_	ted 2 resident, Residents			inserviced on reporting changes of condition to the MD timely.		
	C and D, in a sar	nple of 3.			UM/designee will monitor		
					compliance 5 x weekly through the		
	Findings include	:			change of condition audit. Patterns		
					of non-compliance will be addressed	t l	
	1. The clinical r	ecord of Resident C was			through progressive discipline.		
	reviewed on 12/	19/11 at 1:45 p.m. and			4. Results of audits will be		
		ident was admitted to the			forwarded to QA&A monthly		
		11, with diagnoses			times 3 months for tracking and		
	· ·	ot limited to, diabetes, and			trending and quarterly thereafte	r	
	J	izing fascitis of the					
	scrotum.	ming runging of the					
	Serotain.						
	Review of a Cha	inge of Condition Skin					
	Sheet, dated 11/2	21/11 at 11:00 p.m.,					
	indicated the following	lowing:					
	"Res (resident) c	complained of toe					
		sock found 4 diabetic					
		ection 3 on 2nd (second)					
		foot, et (and) 1 of his 3rd					
	` • /	at amount of blood					
	, ,	A (open area) on 2nd					
	_	toenail. Skin under toe is					
	· ·	c/o (complaints) pain.					
		dressing et (and)					
	** '	hysician's name).					
	`	cycline (antibiotic) po (by					
	1	o times a day) x (times) 2					
	′ ` `	• / \ /					
		omplete Blood Count					
	• /	PT/PTT (Protime and					
	Prothrombin Tin	ne laboratory test) et appt					

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Event ID: M1VR11

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155446	B. WIN			12/21/2011
NAME OF B	DROWINED OR CLIDDLIED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			5700 W	ILKIE DR	
		TH AND REHABILITATION CEN	NTER	<u> </u>	VAYNE, IN 46804	
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	COMPLETION DATE
TAG		*		TAG		DATE
	\ 11 / \ / \	vith) wound clinic. Res				
	aware"					
	A narrative nursi	ing note, dated 11/22/11				
		icated the dressing was				
		nd and 3rd toes, the 2nd				
	_	bright red, and warm.				
	· ·	also indicated there was				
		to the tip and bottom of				
		a small area to the top of				
		oderate amount of				
	drainage to both					
	Nursing notes, d	lated on 11/23/11				
	indicated the dre	ssing to the toes was				
	clean, dry, and ir	ntact, and the antibiotic				
	was being given.					
	There was no do	cumentation the				
	physician was no	otified regarding the black				
	areas on the toes	, until 11/24/11 at 6:30				
	p.m. A nursing	note, dated 11/24/11 at				
	6:30 p.m., indica	ated the antibiotic				
	treatment continu	ued for the diabetic ulcers				
	on the right 2nd	*				
	"ordered xerofor					
	There was no do	cumentation in the note				
	that the physician	n was made aware of the				
	black toes.					
	However, a phys	ician's order, dated				
	11/24/11, indicat	ted xeroform dressing to				
	the right 2nd and	1 3rd toes twice a day.				
	A nursing note,	dated 11/25/11 at 10:00				

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446	A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/21/	ETED
		155440	B. WIN			12/21/	2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	ITER	FORT V	VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROJUDERIC DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	NTE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	DATE
	a m indicated t	he dressing was changed					
		d right toes, the diabetic					
		to the 2nd and 3rd					
	_	e 2nd digit had an open					
		or toe, and the drainage					
		h a foul odor. The note					
		I digit inferior open area					
	was black in cold	or with surrounding skin					
	pink and peeling	, the 2nd and 3rd					
	superior open are	ea's wound beds were					
	yellow/red, and t	he surrounding skin					
	peeling and pink						
	F	•					
	A nursing note	dated 11/27/11 at 1:00					
		ne resident continued on					
		infection to the right toes,					
		r noted, but purulent					
	drainage was not	red.					
	A narrative nursi	ng note, on the back of					
		nentation flow sheet, and					
		t 11:30 p.m., indicated					
		-					
		ulated per self using a					
	· ·	independent with					
		living. The note					
		as a purulent, foul					
	smelling drainag	e noted, and a black area					
	to the 3rd toe, an	nd open area to the 2nd					
	toe.	-					
	A non nressure s	kin condition report,					
	_	_					
		ndicated the resident had					
	necrotizing fasci	tis to bilateral feet.					
			\perp				

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Event ID: M1VR11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155446	B. WIN			12/21/2011
NAME OF B	DROWNER OF GUIDNI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			5700 W	ILKIE DR	
		TH AND REHABILITATION CEN	NTER		VAYNE, IN 46804	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		dated 11/28/11 (no time)				
		ident had necrotizing				
		al feet, the right foot was				
		discoloration and				
		odor noted, the left foot				
		rple discoloration,				
		t, and an odor. The				
	resident had no c	complaints of pain, the				
	physician was no	otified and the resident				
	sent to the emerg	gency room for				
	evaluation.					
	Review of an acu	ite hospital transfer				
	record, dated 11	/28/11, indicated the				
		sferred to the hospital at				
	10:30 a.m. on 11	_				
	A nursing note,	dated 12/5/11, indicated				
	the resident was	hospitalized.				
		-				
	A history and ph	ysical, dated 11/28/11,				
	from the local ho	ospital, indicated the				
		gnoses including, but not				
		2 diabetes, anemia,				
		story of necrotizing				
	fascitis left thigh	-				
		istory and physical				
		ident was transferred				
		home with cellulitis and				
	possible osteomy					
	^	m indicated bilateral				
	second digit foot					
		foot showed suspicious				
	tor only findings	for 2nd distal phalanx,				

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Event ID: M1VR11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLETED
		155446	A. BUI. B. WIN	LDING		12/21/2011
		<u> </u>	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEF	R			ILKIE DR	
COVING	TON MANOR HEAI	LTH AND REHABILITATION CE	NTER		VAYNE, IN 46804	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWINEDIS DI ANI OE CORRECTIONI	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	could be related	to osteomylitis and				
	healing fracture of the base of the 1st phalanx of the left foot showed fracture of					
	^	nd phalanx. Also right				
		owed findings suggestive				
		owed infames suggestive				
	of osteomylitis.					
		1 . 110/7/11				
		gress note, dated 12/7/11,				
		ident was diagnosed with				
		ion, osteomylitis,				
	peripheral arteria	al disease, and diabetes.				
	The Director of	Nursing Services (DNS),				
	was interviewed	on 12/20/11 at 9:05 a.m.,				
		e physician was notified				
		ndition of the toes on				
		new order was received				
	for xeroform dre	essing.				
	The facility police	cy received by the DNS				
		0:00 a.m., Managing				
		ition updated 10/2011				
	_	ne change in condition				
		•				
		life-threatening, the				
		may be followed:2.				
	Notify physician	of assessment				
	findings"					
	Pagidant C	interviewed at 11:00				
		interviewed, at 11:00				
		, and indicated he				
		n his toes and the toes				
	were bleeding, se	o he reported this to the				
	staff. He indicat	ted he had to have 2 of				
	his toes ambulate	ed after this.				

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PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	(X3) DATE S COMPL		
		155446	A. BUI B. WIN	LDING IG		12/21/	2011
NAME OF I	PROVIDER OR SUPPLIER	\		1	ADDRESS, CITY, STATE, ZIP CODE		
COVING	TON MANOR HEAI	LTH AND REHABILITATION CEN	TFR	1	'ILKIE DR VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES	T	ID	·		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	The DNS was in	terviewed, on 12/21/11					
		l indicated Resident C did					
		zing fascitis of his					
		e indicated the wound					
		nented this diagnosis, but					
		diagnosed as having					
	osteomynus, not	necrotizing fascitis					
	2. The clinical r	ecord of Resident D was					
		19/11 at 10:00 a.m.,					
		e resident was readmitted					
	1	10/20/11, with diagnoses of limited to, diabetes,					
		lisease and coronary					
	artery disease.	inscuse una coronary					
	-						
		ssion assessment, dated					
	· ·	ated the resident had a					
	~	abdominal folds, a upper/inner arm, 3+					
		the bilateral lower					
		anticubital bruising, and					
	a left hip replace						
		_					
		assessment for predicting					
	1 ^	k was completed on					
		11/10/11, and indicated not at risk for pressure					
	sores.	not at risk for pressure					
		neet for October, 2011,					
	indicated weekly	skin assessments were					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE SURV	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED	
		155446	B. WIN			12/21/2011	l
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
COMPIC	TON MANOD HEA	LTH AND REHABILITATION CEN	TED		ILKIE DR VAYNE, IN 46804		
			IER		VATINE, IIN 40004		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	001	(X5)
PREFIX TAG	, and the second	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	MPLETION DATE
TAG	<u> </u>	lmission and again on		IAG	,		DATE
	10/27/11.	imission and again on					
		s for November, 2011,					
		y skin assessments were					
	completed.	y Skill assessments were					
	compicted.						
	A nursing note	dated 10/30/11 at 12					
		the physician was notified					
	•	ent having 3+edema, and					
		e left for Bumex to be					
		l lab ordered for 11/1/11.					
	1 0	o indicated she just felt					
	bad.	5 indicated she just left					
	oau.						
	Δ nursing note	dated 10/31/11 at 10:50					
	1	"dark purple dti (deep					
		ted to 1 (left) foot, lateral					
		alloused skin surrounding.					
		o(complained of) mild					
		pon exam or pressure c					
		ht bearing. Edemas 3+					
	` ′	s bilat (bilateral) LE					
	(lower extremiti	,					
	(lower extremiti	es).					
	The Pressure III	cer Evaluation Form,					
		indicated the resident had					
	· · · · · · · · · · · · · · · · · · ·	ury on the left foot, which					
		timeters(cm) in length					
		idth with no drainage.					
		dition report, dated					
	_	ted the physician was					
	· ·	/30/11 at 12 noon,					
		,					
		w area, but left no new					
	orders.		1				

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Event ID: M1VR11

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPI	
		155446	B. WIN			12/21	/2011
	PROVIDER OR SUPPLIER	TH AND REHABILITATION CEN	ITER	5700 W	NDDRESS, CITY, STATE, ZIP CODI ILKIE DR VAYNE, IN 46804	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	deep tissue injury or maroon localizintact skin or blo damage of under pressure and/or state and pressure ulcer 10/31/11, indicate the left foot arch, 2.5 cm, which was and pink surround. Physician orders indicated cover to with a dry abdom loose kerlix, chastor loosening/soin Also a venous do to the bilateral los swelling and paint thrombosis. Another physicial indicated bilatera wraps with lymp ordered due to expect the desired product of desired products of desired products. A bilateral lower ultrasound test, and evidence of desired products of desired products. A pressure ulcer the damage of t	evaluation form, dated ed an unstageable area to measuring 1.2 cm by as 100 percent eschar, ding skin with swelling. I dated 11/1/11, he left lateral foot archanal pad and fix with ange daily and as needed lage. I oppler study was ordered wer extremities, for a to rule out deep vein an order, dated 11/1/11, all extremity compression hatic massage was dema. I extremity venous dated 11/2/11, indicated eep vein thrombosis wer extremities					
	11/7/11, indicate	d the area was					

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STATEMEN	NT OF DEFICIENCIES	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLETED	
		155446	B. WIN			12/21/2011	
NAME OF F				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	C		5700 W	ILKIE DR		
	TON MANOR HEAL	TH AND REHABILITATION CEN	ITER	FORT V	VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	` `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		ON
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC!)	DATE	
	1	percent eschar, and					
	measured 1.1 cm	measured 1.1 cm by 3.0 cm.					
	An occupational therapy daily treatment note, dated 11/16/11, indicated resident						
		on 11/15/11, and the					
	therapist was wit	•					
	•	ps due to the abnormal					
	lab results.						
	l						
		py progress report, dated					
	· ·	ted the open area to the					
	_	proving, but now noted a					
	small pressure ar	rea laterally to the right					
	foot, and nursing	g was notified.					
	A norrotivo nuro	ing note dated 11/19/11					
		ing note, dated 11/18/11,					
	1	dicated a new wound					
	_	eted for a small, dry,					
		y to the lateral side of the					
	_	aring 2 cm by 2 cm.					
	_	evaluation form, dated					
	1	ted there was a deep					
		he right foot, lateral side,					
	_	by 2 cm, no odors, no					
		ialization, hard/scarred					
	wound edges, an	d pink surrounding skin.					
	A proceure ulcer	evaluation form, dated					
	_						
		ted the area on the right					
	_	eable, measured 0.5 by 0.8					
	· ·	rainage, 100 percent					
		dges defined, and the					
	surrounding skin	was pink.					

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Event ID: M1VR11

Facility ID: 000476

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	NSTRUCTION	,	LETED	
AND PLAN	OF CORRECTION	155446	A. BUI	LDING	00		/2011
		133440	B. WIN			12/21	72011
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
COMING	TON MANOD HEAD	LTH AND REHABILITATION CEI	ITED		ILKIE DR VAYNE, IN 46804		
			VIEK	<u> </u>	VATNE, IN 40004		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
TAG	REGULATORT OR	LESC IDENTIFY TING INFORMATION)	+	IAG			DATE
	A prossure ulear	evaluation, dated					
	_						
12/12/11, indicated the area was healed to the right foot.							
	to the right root.						
	On 11/22/11 tha	resident was transferred					
		or a scheduled blood					
	transfusion.	or a scrieduled blood					
	transfusion.						
	A proggues ulas	avaluation dated					
A pressure ulcer evaluation, dated 12/19/11, indicated the area located on the							
		asured length was 0.8					
		•					
	centimeters (cm)	and 1.8 cm.					
	On 12/20/11 at 1	2:15 p.m. the LPN					
		as interviewed in regard					
		ne pressure ulcers and she					
		ought the pressure ulcers					
		the resident had					
	cellulitis and ede						
	cenunus and ede	zilia.					
	On 12/20/11 at 1	2:45 p.m. the Certified					
		erapy Assistant (COTA)					
	-	in regard to the					
		aps and indicted the					
	_	e compression wraps for					
		days a week. The					
	1	dicated she applied the					
		ne week and Nursing					
		s on the week-ends and					
	_	COTA were responsible					
	_	residents bilateral legs					
	_	were removed for 1 hour					
	a day.						

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Event ID: M1VR11

Facility ID: 000476

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PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		A. BUILDING B. WING		COMPLETED 12/21/2011	
	PROVIDER OR SUPPLIER TON MANOR HEALTH AND REHABILITATION CEN	TER	5700 W	ADDRESS, CITY, STATE, ZIP CODE ILKIE DR VAYNE, IN 46804		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	On 12/20/11 at 4:55 p.m. the Director Nursing Service (DNS) was interviewed in regard to the resident's pressure ulcer and she indicated the resident only wore shoes in therapy after the first pressure ulcer developed. The DNS further indicated the resident had a special pressure reduction mattress with a "heel slope" On 12/21/11 at 10:45 a.m. an observation of the resident's pressure area with RN #3 was obtained to the left foot arch and the wound bed was pink and surrounding tissue were pink and slightly swollen with a scant amount of serosanguineous drainage on the old dressing. This federal tag relates to complaint IN00101272 3.1-5(a)(2)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155446	B. WIN			12/21/	2011
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ILKIE DR		
COVING	TON MANIOD HEAL	TH AND REHABILITATION CEN	TED		VAYNE, IN 46804		
			ILIX	TOKTV	WATNE, IN 40004		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY COARE PLAN The services profacility must be pin accordance wiplan of care. Based on interviethe facility failed care plans were finotification of the Resident C, who condition resulting surgery and failed Registered Dietic reassessment of the completed (Resident C) whose care plans Findings include 1. The clinical reviewed on 12/1 indicated the resifacility on 11/1/1 including, but no history of necrotic scrotum. The Minimum Double Assessment, date resident scored 1	QUALIFIED PERSONS/PER avided or arranged by the provided by qualified persons ith each resident's written avided or arranged by the provided by qualified persons ith each resident's written avided to ensure the resident's collowed in regard to each to ensure the color was notified and a state resident's needs was dent B). affected 2 of 3 residents as were not followed. becord of Resident C was 19/11, at 1:45 p.m. and ident was admitted to the 1, with diagnoses at limited to, diabetes, and izing fascitis of the	F02		1. The MD was notified of the change of condition on 11/24/1 for resident C. Resident B no longer resides in the facility.2. residents were reviewed for changes in skin conditions with MD notification as appropriate. As stated in the 2567, an audit was completed on 12/14 and 12/15/11 of the dietary progres notes and all progress notes h since been updated. 3. Licenturses will be inserviced on completing weekly skin assessments timely and notify the MD of changes of condition UM/designee will monitor compliance 5 x weekly through the change of condition audit. Patterns of non-compliance wibe addressed through progressive discipline. The Dietary Manager has been inserviced on completing progress notes timely. ED/designee will monitor through audits of 5 residents 2 times per week for 1 month, followed by 5 residents weekly 2 months and 5 times a month 3 months therafter. 4. Results audits will be forwarded to QAM monthly times 3 months for tracking and trending and	All in is is sed ing ins. if if if if if if if if if i	01/20/2012

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		(X2) N	MULTIPLE CO	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED	
		155446	B. WI			12/21/2011	
NAME OF S	DD OLUDED OD GUDDI IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	K		5700 W	ILKIE DR		
COVING	TON MANOR HEA	LTH AND REHABILITATION CEN	ITER	FORT V			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	for dressing, toil	let use, personal hygiene,			A dietician communication form has	5	
	and bathing.				been placed at the nurses stations		
					for completion. The dietician then		
	Review of the N	Jursing Admission			reviews these forms for any require follow up on each visit weekly.	a	
	Assessment, dat	ed 11/1/11, indicated a			ED/Designee will review the follow		
	skin graft to the	right thigh, measuring 25			up during previously stated random		
	1) by 18 cm., and a skin			audits, ED/designee will monitor		
	`	s. There were no other			through random audits of 5		
	skin conditions				residents 2 times per week for 1		
	assessment.				month, followed by 5 residents		
	Care plans were reviewed on 12/19/11. A skin integrity care plan, dated 11/7/11,				weekly for 2 months and 5 times a		
					month for 3 months thereafter.		
	1	ntial for impaired skin					
	1 "	to recent surgery, with					
	_	d to impaired mobility and					
	Diabetes Mellitu						
		r this problem included,					
	but were not lim						
		hysician promptly of skin					
	breakdown;						
	D						
		reatment sheet for					
	1	l, indicated weekly skin					
		re completed on 11/2,					
	11/9, 11/17, and	11/24/11.					
	D : 2 2	0.0 11.1 01.1					
	Review of a Change of Condition Skin						
Sheet, dated 11/21/11 at 11:00							
	p.m.,indicated the	ne following:					
	"Dag (ragidant)	complained of tes					
	` ′	complained of toe					
		h sock found 4 diabetic					
	ulcers upon inspection 3 on 2nd (second)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED
		155446	B. WIN			12/21/2011
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				ILKIE DR	
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	ITER		VAYNE, IN 46804	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	toe of res (right)	foot, et (and) 1 of his 3rd				
	(third) toe. slight amount of blood					
	draining from Oa	A (open area) on 2nd				
	toe's ulcer, near t	oenail. Skin under toe is				
	· ·	c/o (complaints) pain.				
		dressing et (and)				
	contacted Dr. (Pl	• , ,				
	`	cycline (antibiotic) po				
	1	(two times a day) x				
		• •				
	. / /	CBC (Complete Blood				
	1	test) PT/PTT (Protime				
		Time laboratory test) et				
	appt (appointme	nt) (with) wound clinic.				
	Res aware"					
	A narrative nursi	ng note, dated 11/22/11				
	at 2:00 p.m., indi	icated the dressing was				
	changed to the 2	nd and 3rd toes, the 2nd				
	_	bright red, and warm.				
	· ·	also indicated there was				
		to the tip and bottom of				
		a small area to the top of				
	· ·	oderate amount of				
	•					
	drainage to both	wes.				
	Nursing notes, d	lated on 11/23/11				
		ssing to the toes was				
		ntact, and the antibiotic				
	was being given.	·				
	was being given.					
	There was no do	cumentation the				
	physician was no	otified regarding the black				
	1 2	, until 11/24/11, at 6:30				
		-				
	p.m. A nursing	note, dated 11/24/11, at				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155446	B. WIN	IG		12/21/2011
NAME OF F	PROVIDER OR SUPPLIER		_	STREET A	DDRESS, CITY, STATE, ZIP CODE	
TWINE OF T	KO VIDEK OK SOIT EIEN				ILKIE DR	
COVING	TON MANOR HEAL	TH AND REHABILITATION CE	NTER	FORT V	VAYNE, IN 46804	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ated the antibiotic				
		ued for the diabetic ulcers				
	_	and 3rd toes, and				
	"ordered xerofor					
		cumentation in the note				
		n was made aware of the				
	black toes.					
	, 1 3	ician's order, dated				
	· · · · · · · · · · · · · · · · · · ·	ted xeroform dressing to				
	the right 2nd and	1 3rd toes twice a day.				
		dated 11/25/11, at 10:00				
		he dressing was changed				
		d right toes, the diabetic				
	ulcers continued	to the 2nd and 3rd				
	superior toes, th	e 2nd digit had an open				
	area on the inferi	for toe, and the drainage				
	was purulent wit	h a foul odor. The note				
	indicated the 2nd	l digit inferior open area				
	was black in cold	or with surrounding skin				
	pink and peeling	, the 2nd and 3rd				
	superior open are	ea's wound beds were				
	yellow/red, and t	the surrounding skin				
	peeling and pink					
		dated 11/27/11 at 1:00				
		ne resident continued on				
		infection to the right toes,				
		or noted, but purulent				
	drainage was not	ted.				
		ing note, on the back of				
		nentation flow sheet, and				
	dated 11/27/11, a	at 11:30 p.m., indicated				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED 12/21/2011			
		155446	B. WIN	G		12/21	/2011	
	PROVIDER OR SUPPLIER	TH AND REHABILITATION CEN	ITER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR TER FORT WAYNE, IN 46804				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROIDEFICIENCY)	BE	(X5) COMPLETION DATE	
	walker, and was activities of daily indicated there w smelling drainag	ulated per self using a independent with viving. The note ras a purulent, foul e noted, and a black area and open area to the 2nd						
	dated 11/28/11, i	kin condition report, ndicated the resident had tis to bilateral feet.						
	indicated the resi fascitis to bilater pale with purple streaking noted, was pale with pu streaking present resident had no c	dated 11/28/11 (no time) dent had necrotizing al feet, the right foot was discoloration and odor noted, the left foot rple discoloration, and an odor. The complaints of pain, the otified and the resident sency room for						
	record, dated 11	tte hospital transfer /28/11, indicated the sferred to the hospital at /28/11.						
	A nursing note, the resident was	dated 12/5/11, indicated hospitalized.						
		ysical, dated 11/28/11, spital, indicated the						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155446	B. WIN			12/21/2011
NAME OF F	DROVADED OD GLIDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			5700 W	ILKIE DR	
		TH AND REHABILITATION CEN	ITER	<u> </u>	VAYNE, IN 46804	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)	DATE
	1	noses including, but not				
	limited to: type 2 diabetes, anemia,					
		story of necrotizing				
	fascitis left thigh					
	~ ~	istory and physical				
	indicated the resi	ident was transferred				
	from the nursing	home with cellulitis and				
	possible osteomy	litis.				
	The physical exa	m indicated bilateral				
	second digit foot	gangrene.				
	Xray of the right	foot showed suspicious				
		for 2nd distal phalanx,				
		to osteomylitis and				
		of the base of the 1st				
	_	ft foot showed fracture of				
	•	nd phalanx. Also right				
		owed findings suggestive				
	of osteomylitis.	owed findings suggestive				
	of osteomynus.					
	A physician prog	gress note, dated 12/7/11,				
		ident was diagnosed with				
		on, osteomylitis,				
	_	al disease, and diabetes.				
	F					
	The Director of 1	Nursing Services (DNS),				
		on 12/20/11, at 9:05				
		ted the physician was				
		g the condition of the				
	_	l, and a new order was				
	received for xero	norm aressing.				
		nterviewed, at 11:00				
	a.m., on 12/21/11	1, and indicated staff				
	assisted him with	n washing his back and				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155446	B. WIN	G		12/21/2011
NAME OF E	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUFFLIER			5700 W	ILKIE DR	
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	NTER	FORT V	VAYNE, IN 46804	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		er. He indicated he				
	noticed a scab on his toes and the toes					
	were bleeding, so	o he reported this to the				
	staff. He indicat	ed he had to have 2 of				
	his toes ambulate	ed after this.				
	The DNS was in	terviewed, on 12/21/11				
	at 2:15 p.m., and	indicated Resident C did				
	_	zing fascitis of his				
	bilateral feet. She	e indicated the wound				
		ented this diagnosis, but				
		diagnosed as having				
		necrotizing fascitis				
		mountained amounts				
	2 The closed re	ecord for Resident B, was				
		5 a.m., on 12/19/11.				
		admitted to the facility				
		diagnoses, including,				
		-				
	but not limited to	· • •				
	l "	y Tract Infections (UTIs),				
		ross Hematuria, Anemia,				
		Retention, Urolithiasis,				
	1	acral decubitus ulcer.				
		edication Administration				
		mber, 2011, also				
		sugars were checked				
	before meals and	l at bedtime, and the				
	resident was on s	sliding scale insulin				
	coverage.					
	Review of a Hist	ory and Physical, dated				
	8/20/11, from a	local hospital (hospital				
	1), indicated the	resident had a past				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RII	ILDING	00	COMPL	ETED
		155446	B. WIN			12/21/	2011
			1	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ILKIE DR		
COVING	TON MANOR HEA	LTH AND REHABILITATION CEN	ITER		VAYNE, IN 46804		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, and the second	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	of Quadriplegia after a					
	neck injury, Stat	tus post supra pubic					
	catheter in 1980	, Sacral decubitus ulcer,					
	Recurrent UTIs,	, and Debridement of a					
	sacral decubitus	in the past.					
		•					
	Review of anoth	ner History and Physical,					
		cal hospital (hospital 2),					
		11, indicated the resident					
		hospital 1 on 8/19/11					
		•					
	because of hematuria and urosepsis, developed perforation and had septic						
		•					
		o respiratory failure from					
	_	had a tracheostomy. The					
		nsferred to hospital 2 on					
	10/3/11, for cor	ntinued antibiotics and					
	recuperation, ha	ad not been able to eat and					
	was fed through	a Gastrostomy tube.					
	A nursing admis	ssion assessment, dated					
	_	ted the resident had a					
	•	are ulcers, and was					
		e a scar on the coccyx, and					
		area on the right toe, but					
		nditions. The initial skin					
		ted included pressure					
		*					
	_	ss, repositioning program,					
		e management. The					
		revealed the resident had					
	_	ce and a Gastrostomy					
	tube.						
	A nursing note.	dated 11/7/11 at 4:45					
	_	the resident was admitted					

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Event ID: M1VR11

Facility ID: 000476

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	î î	ATE SURVEY MPLETED	
AND TEAN	or condition	155446		LDING			21/2011
			B. WIN		DDDEGG CITY CTATE ZID C		
NAME OF F	PROVIDER OR SUPPLIE	₹			.DDRESS, CITY, STATE, ZIP C ILKIE DR	ODE	
COVING	TON MANOR HEA	LTH AND REHABILITATION CE	NTFR		VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(V5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE	HOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	with a tracheosto	omy, peg tube and was to					
		ic centimeters (cc) an					
	hour from 8:00 p.m., to 6:00 a.m., had a						
	_	s on a mechanical soft					
	diet.						
	A nutrition scree	ening and assessment,					
	dated 11/11/11,	indicated the resident					
	was receiving a	supplement, Pivot, at 50					
	cc hour at night,	and skin was intact.					
	A Braden scale assessment, for predicting pressure sore risk, indicated						
	assessments wer	re completed on 11/7/11,					
	11/21/11, and 1	1/28/11, and indicated					
	the resident scor	ed "9" with a total score					
	of 12 or less repr	resenting a high risk for					
	pressure sore.						
	•	evaluation record, dated					
	11/26/11, indica						
		ge 2 pressure ulcer on the					
		easuring 2.0 centimeters					
		no odor, scant serous					
		anulating, and intact					
	surrounding skir	1.					
	A reassessment.	completed on 11/28/11,					
	indicated the san	•					
	information as w	vas documented on					
	11/26/11.						
	A nursing note,	dated 11/29/11					
	_	ident was started on an					
		enously, for 10 days, due					

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If continuation sheet

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING O			(X3) DATE SURVEY COMPLETED	
		155446	B. WIN			12/21/	2011	
	PROVIDER OR SUPPLIER	LTH AND REHABILITATION CEN	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	no further documentes regarding to resident's buttood dated on 12/3/11 the sacral wound and granulation amount to blood slight odor, no stinfection. A nursing note, a.m., indicated the have the wound applied as ordered percent slough a and the wound wound edges attained to have wound edges attained to have wound edges attained to have the wound wound edges attained to have wound edges attained to have wound edges attained to edge. Review of the ultimated to have wound edges attained to ensure the sacration of the work of the ultimated to ensure the sacration of the work of the ultimated the value of the val	cer evaluation record, ndicated the wound a. by 6.0 cm, had an odor, anguineous drainage, 50 pink surrounding skin,						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155446	B. WIN			12/21/2011	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
COVING	TON MANOR HEA	LTH AND REHABILITATION CE	NTER		ILKIE DR VAYNE, IN 46804		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
		nin C 500 milligrams twice					
	1 -	vs, and Zinc 220					
		ry day for 30 days, to					
	the Wound Clin	healing, and a referral to					
		ian order, dated 12/4/11,					
	1 2	vot tube feeding was					
		nd the resident was to be					
	started on Diabe						
	Started on Diable	ctasource.					
	A change in cor	ndition report, dated					
	_	00 p.m., indicated the					
	· ·	nt to the emergency room					
		to get adequate air					
	1	gh his tracheostomy.					
	,	dated 12/5/11, at 2:00					
		the resident had returned					
	from the hospita						
	tracheostomy.	,					
	A nursing note,	dated 12/7/11, at 4:00					
	p.m., indicated	the resident was informed					
	the physician ha	nd recommended treatment					
	at the wound cli	inic. The note indicated					
	the resident refu	used the appointment due					
	to problems wit	h the area on his buttocks					
	opening from ti	me to time. The resident					
	indicated, "he k	new his body and knew					
	what the doctor	will say, so he would					
	rather tx (treat)	like he has in the past, and					
	will follow up c	(with) wound clinic if					
	needed after he	does what the doctor has					
	ordered in the p	ast."					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155446	B. WIN			12/21/2011
NAME OF B	DROWNER OF GUIDNI IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			5700 W	ILKIE DR	
		TH AND REHABILITATION CEN	ITER		VAYNE, IN 46804	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE)	DATE
		d 11/11/11, indicated a				
	1 ^	aired skin integrity				
	related to Quadriplegia, impaired					
	-	nence, pain, and history				
	of breakdown.					
		luded, but not limited to:				
	pressure reducing	g mattress to bed,				
	pressure reducing	g cushion to wheelchair,				
	observe skin inte	grity during am/pm care,				
	refer to RD (regi	stered dietician) as				
	needed to evalua	te diet/needs, evaluate				
	skin weekly, and	low loss air mattress.				
	,					
	A nutrition scree	ning and assessment,				
		indicated the skin was				
	intact.					
		utritional progress note,				
	1	was documented by the				
	•	and indicated the				
	1	a mechanical soft diet,				
		as 210 pounds, and Pivot				
	I -	ube feeding. There was				
		-				
	1	or interventions on the				
		ng the development of				
	the pressure sore	•				
	A discharge inst	ruction sheet, dated				
	1	d the resident was				
		me with home health				
	_	were to provide 24 hour				
	care, and mends	were to provide 24 flour				
		report, dated 12/9/11,				
		dicated the resident had				
	_	ith buttocks excoriation,				
ı	saciai wounds w	im buttocks excortation,				1

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PRINTED: 04/13/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/21/2011			
	PROVIDER OR SUPPLIER	LTH AND REHABILITATION CEN	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	3 NATE	(X5) COMPLETION DATE	
	on 12/19/11, and did not have any admitted, but has sores. She indicated a history of placed on a low mattress, and problem his wheelchair, and additional dietary documented, and was no longer erobad resigned, which will be sometimes to be sometimes and also when dietary notes to be sometimes and also when dietary and also when dietary notes did skin a resident on a wear esidents at risk in the sore.	terviewed, at 2:35 p.m., d indicated the resident open areas when he was d a history of pressure ated because the resident pressure sores, he was loss alternating air essure cushion placed in on admission.					

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	of correction identification number: 155446		ILDING	00	COMPI 12/21	LETED	
	PROVIDER OR SUPPLIER TON MANOR HEALTH AND REHABILITATION CEN	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR TER FORT WAYNE, IN 46804					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE	
	Integrity Process" policy, provided by the Director of Nursing Services (DNS), at 10:00 a.m., on 12/20/11, indicated the following: Dietary support would include additional nutritional supplement or fortified diet according to the Registered Dietician's recommendations; Revise care plan as appropriate. This federal tags relates to complaint IN00101272. 3.1-35(g)(2)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155446	B. WIN			12/21/	2011
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CENT	ER	FORT V	VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0309 SS=G	483.25 PROVIDE CARE WELL BEING Each resident mi must provide the services to attain practicable physi psychosocial we the comprehensi care. Based on intervice the facility failed services were pro- development of o promptly notify t change in conditi that resulted in o and surgical amp	ust receive and the facility necessary care and or maintain the highest ical, mental, and ill-being, in accordance with ve assessment and plan of ews and record reviews, it to ensure care and evided to prevent the diabetic ulcers and to the Physician with a ion of the resident's toes steomylitis of the bone, outation of the to the	F03		1. The MD was notified of change of condition on 11/24/r for resident C.2. All residents were reviewed for changes in conditions with MD notification appropriate.3. Licensed nurse will be inserviced on reporting changes of condition to the MI timely. UM/designee will monicompliance 5 x weekly through	skin i as es O	01/20/2012
	second toe of the This deficiency a Resident C, in a s Findings include	affected 1 resident, sample of 3.			the change of condition audit. Patterns of non-compliance wi be addressed through progressive discipline.4. Resu of audits will be forwarded to QA&A monthly times 3 month for tracking and trending and	ılts	
	reviewed on 12/1 indicated the resifacility on 11/1/1 including, but no history of necrotiscrotum. The Minimum D Assessment, date resident scored 1	rd of Resident C was 19/11, at 1:45 p.m. and dent was admitted to the 1, with diagnoses at limited to, diabetes, and dizing fascitis of the ata Set(MDS) atd 11/11/11, indicated the 5/15 on the Brief ental Status (BIM), and			quarterly thereafter.Addendum A dietician communication form has been placed at the nurses stations for completion. The dietician then reviews these forms for any require follow up on each visit weekly. ED/Designee will review the follow up during previously stated random audits, ED/designee will monitor through random audits of 5 residents 2 times per week for 1 month, followed by 5 residents weekly for 2 months and 5 times a month for 3 months thereafter.	d	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPLETED
		155446	B. WIN			12/21/2011
NAME OF P	DROWNER OF GURBLES			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	•		5700 W	ILKIE DR	
		TH AND REHABILITATION CEN	ITER		VAYNE, IN 46804	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	, The state of the	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
	•	assistance of one person			C.N.A.'s have been inserviced on	
		et use, personal hygiene,			reporting changes in skin color or condition to the nurse. The C.N.A	
	and bathing.				documentation system prompts	
					staff during showers/bed baths to	
	Review of the N	ursing Admission			report to nurse any warm,	
	Assessment, date	ed 11/1/11, indicated a			discolored, or open areas. All	
	skin graft to the	right thigh, measuring 25			residents receive at a minimum	
	•	by 18 cm., and a skin			three observations weekly regarding	g
	` ′	. There were no other			the condition of their skin. The	
	skin conditions i				license nurse documents the	
	assessment.	definition on the			condition of each residents skin	
	assessificit.				weekly. Additionally there are observations of the residents skin	
	Coro plone wore	reviewed on 12/19/11.			during their, at a minimum, 2	
	•				scheduled shower times weekly.	
		care plan, dated 11/7/11,			Unit managers will validate weekly	
	_	itial for impaired skin			skin assessment accuracy through	
		to recent surgery, with			random audits of a total of 5	
	1 ^	to impaired mobility and			observations weekly.	
	Diabetes Mellitu					
	Interventions for	this problem included,				
	but were not limi	ited to:				
	observe skin i	integrity during morning				
	and evening care					
	notify the phy	sician promptly of skin				
	breakdown;					
	evaluate skin	weekly.				
		n, dated 11/1/11, for self				
	_	ated the resident required				
		e for bed mobility,				
		• •				
	transfers, ambulation, dressing, personal					
	hygiene, bathing, and toilet use.					
	Interventions for this problem included,					
	but not limited to					
		ysical assist for bed				
	mobility, transfer	rs, ambulation,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155446	B. WIN	G		12/21/	2011
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	ITER	FORT V	VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	sing, toilet use, and					
	bathing.						
	Review of the tre						
	· ·	, indicated weekly skin					
	assessments were	e completed on 11/2,					
	11/9, 11/17, and	11/24/11.					
		nge of Condition Skin					
	Sheet, dated 11/2						
	p.m.,indicated th	e following:					
	` ′	complained of toe					
		sock found 4 diabetic					
	ulcers upon inspe	ection 3 on 2nd (second)					
	toe of res (right)	foot, et (and) 1 of his 3rd					
	(third) toe. sligh	t amount of blood					
	draining from Oa	A (open area) on 2nd					
	toe's ulcer, near t	oenail. Skin under toe is					
	very pale. (No)	c/o (complaints) pain.					
	Wrapped (with)	dressing et (and)					
	contacted Dr. (Pl	• , ,					
	`	cycline (antibiotic) po					
	_	(two times a day) x					
	. •	CBC (Complete Blood					
		test) PT/PTT (Protime					
	_	Time laboratory test) et					
		nt) (with) wound clinic.					
	Res aware"	ing (with) would cillic.					
	ines awaie						
	A narrativa nurci	ng note, dated 11/22/11					
		icated the dressing was					
	_	nd and 3rd toes, the 2nd					
	toe was swollen,	bright red, and warm.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155446	B. WIN			12/21/2011
NAME OF P	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE	
COVING	TON MANOR HEAI	LTH AND REHABILITATION CEI	NTER		ILKIE DR VAYNE, IN 46804	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	ì ·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		also indicated there was				
		to the tip and bottom of				
	the 2nd toe, and a small area to the top of the toe, with a moderate amount of drainage to both toes.					
	dramage to both	ioes.				
	Nursing notes, d	dated on 11/23/11				
	indicated the dre	essing to the toes was				
	clean, dry, and in	ntact, and the antibiotic				
	was being given.					
		e e e				
	There was no do					
		otified regarding the black				
		, until 11/24/11, at 6:30				
	^	g note, dated 11/24/11, at				
		ated the antibiotic				
		ued for the diabetic ulcers				
	"ordered xerofor	and 3rd toes, and				
		cumentation in the note				
		n was made aware of the				
	black toes.					
		sician's order, dated				
	, , ,	ted xeroform dressing to				
	· · · · · · · · · · · · · · · · · · ·	d 3rd toes twice a day.				
ı	A :	1111/05/1110.00				
	_	dated 11/25/11, at 10:00				
		the dressing was changed				
		rd right toes, the diabetic				
		to the 2nd and 3rd				
		e 2nd digit had an open				
		ior toe, and the drainage				
		th a foul odor. The note				
	indicated the 2nd	d digit inferior open area				

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	OF CORRECTION	IDENTIFICATION NUMBER: 155446	A. BUII B. WIN	LDING	00	COMPLETED 12/21/2011	
	PROVIDER OR SUPPLIER	TH AND REHABILITATION CENT		STREET A	ADDRESS, CITY, STATE, ZIP CODE ILKIE DR VAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē.	(X5) COMPLETION DATE
	pink and peeling, superior open are yellow/red, and to peeling and pink.	ea's wound beds were he surrounding skin					
	an antibiotic for i	ne resident continued on infection to the right toes, r noted, but purulent ed.					
	the skilled docum dated 11/27/11, a the resident ambu walker, and was activities of daily indicated there w smelling drainage	•					
	dated 11/28/11, is	kin condition report, ndicated the resident had tis to bilateral feet.					
	indicated the resi fascitis to bilatera pale with purple streaking noted, of was pale with pur	dated 11/28/11 (no time) dent had necrotizing al feet, the right foot was discoloration and odor noted, the left foot rple discoloration, , and an odor. The					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLET	ED
		155446	B. WIN			12/21/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	t .			ILKIE DR		
COVING	TON MANOR HEAI	TH AND REHABILITATION CEN	TER	FORT V	VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		complaints of pain, the					
	physician was notified and the resident sent to the emergency room for						
	evaluation.						
	Review of an acute hospital transfer						
		/28/11, indicated the					
	•	asferred to the hospital at					
	10:30 a.m. on 11	*					
	10.50 4.111. 011 11	/20/11.					
	A nursing note,	dated 12/5/11, indicated					
	the resident was hospitalized.						
		1					
	A history and ph	ysical, dated 11/28/11,					
	1 -	ospital, indicated the					
		gnoses including, but not					
	_	2 diabetes, anemia,					
		story of necrotizing					
	fascitis left thigh						
	_	istory and physical					
	-	ident was transferred					
	_	home with cellulitis and					
	possible osteomy						
		ım indicated bilateral					
	second digit foot						
	1 ,	foot showed suspicious					
		for 2nd distal phalanx,					
		to osteomylitis and					
	_	of the base of the 1st					
	phalanx of the le	ft foot showed fracture of					
	the head of the 2	nd phalanx. Also right					
		owed findings suggestive					
	of osteomylitis.						
]						
	<u> </u>						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE COMPL		
		155446	B. WIN			12/21	/2011
	PROVIDER OR SUPPLIER	TH AND REHABILITATION CEN	ITER	5700 W	DDDRESS, CITY, STATE, ZIP CODE ILKIE DR VAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	indicated the resi	dent was diagnosed with on, osteomylitis, l disease, and diabetes.					
	was interviewed a.m., and indicate notified regarding toes on 11/24/11 received for xero. Resident C was it a.m., on 12/21/11 assisted him with hair in the shower	nterviewed, at 11:00 I, and indicated staff In washing his back and In the indicated he					
	were bleeding, so staff. He indicate his toes ambulate CNA # 1 was int on 12/21/11, and of Resident C on evening shift did She indicated whany residents, she skin and reported nurse. She indicated the assistance when facility, but was	his toes and the toes of he reported this to the ed he had to have 2 of ed after this. erviewed, at 12:03 p.m., d indicated she took care the day shift, but the Resident C's showers. Hen she did showers on e always checked their d anything unusual to the experience to the pretty independent, and self, and toilet himself.					

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	OF CORRECTION IDENTIFICATION NUMBER: 155446		LDING	NSTRUCTION 00	(X3) DATE : COMPL 12/21/	ETED	
	PROVIDER OR SUPPLIER TON MANOR HEALTH AND REHABILITATION CENT	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE	
	The DNS was interviewed, on 12/21/11 at 2:15 p.m., and indicated Resident C did not have necrotizing fascitis of his bilateral feet. She indicated the wound nurse had documented this diagnosis, but the resident was diagnosed as having osteomylitis, not necrotizing fascitis CNA # 2 was interviewed, on 12/21/11, at 2:30 p.m., and indicated she took care of Resident C on the evening shift, and showered him at least weekly. She indicated she washed his back and he was able to wash the rest of his body. She indicated she checked his skin with every shower, head to toe, and reported anything unusual to the nurse. This federal tags relates to complaint IN00101272. 3.1-37(a)						

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Event ID: M1VR11

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155446	B. WIN			12/21/	2011
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			5700 W	ILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CENT	ER	FORT V	VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0314 SS=G	483.25(c) TREATMENT/S\ PRESSURE SOI	/CS TO PREVENT/HEAL RES					
	a resident, the fa resident who ent pressure sores d sores unless the demonstrates tha and a resident ha receives necessa promote healing,	mprehensive assessment of acility must ensure that a ers the facility without loes not develop pressure individual's clinical condition at they were unavoidable; aving pressure sores ary treatment and services to prevent infection and es from developing.					
	Based on observa	ation, record reviews,	F03	14	1		01/20/2012
	and interviews, the	he facility failed to	reside in the facility.2. All				
	•	nent a skin condition			residents were reviewed for changes in skin conditions with		
	_	by the Licensed Nurse to			MD notification as appropriate		
	_	its were complete, failed			As stated in the 2567, an audit		
		gistered Dietician was			was completed on 12/14 and		
	notified and a rea				12/15/11 of the dietary progres		
					notes and all progress notes h		
		was completed to ensure			since been updated.3. Licenson nurses will be inserviced on	ed	
	adequate nutritio	•			completing weekly skin		
		sure ulcer 7 centimeters			assessments timely and notify	ing	
	·	th bloody drainage, slight			the MD of changes of condition		
		ough (Resident B). The			UM/designee will monitor		
	-	ensure Resident D did			compliance 5 x weekly through	1	
		essure ulcers one was a			the change of condition audit. Patterns of non-compliance wi	II	
		y on the left foot and one			be addressed through		
	was an unstageat	ole pressure on the right			progressive discipline. The		
	foot.				Dietary Manager has been		
	This deficiency a	affected 2 residents who			inserviced on completing		
	developed pressu	ire ulcers in a sample of 3			progress notes timely. ED/designee will monitor throu	ah	
	(Resident B and	-			random audits of 5 residents 2	-	
					times per week for 1month,		
	Findings include	:			followed by 5 residents weekly		
					2 months and 5 times a month		
					3 months therafter. 4. Results	ot	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED
		155446	B. WIN			12/21/2011
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER				ILKIE DR	
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	ΓER		VAYNE, IN 46804	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG		
	1. The closed re	ecord for Resident B, was			audits will be forwarded to QA	&A
	reviewed at 10:5	5 a.m., on 12/19/11.			monthly time 3 months for tracking and trending and	
	The resident was admitted to the facility on 11/7/11, with diagnoses, including,				quarterly thereafter.Addendum	,
					C.N.A.'s have been inserviced on	
	but not limited to	o: Quadriplegia,			reporting changes in skin color or	
		Tract Infections (UTIs),			condition to the nurse. The C.N.A	
		ross Hematuria, Anemia,			documentation system prompts	
		Retention, Urolithiasis,			staff during showers/bed baths to	
	* '	acral decubitus ulcer.			report to nurse any warm,	
	1	edication Administration			discolored, or open areas. All	
					residents receive at a minimum	
	Record for December, 2011, also indicated blood sugars were checked				three observations weekly regarding the condition of their skin. The	3
		•			license nurse documents the	
		at bedtime, and the			condition of each residents skin	
		sliding scale insulin			weekly. Additionally there are	
	coverage.				observations of the residents skin	
					during their, at a minimum, 2	
	Review of a Hist	ory and Physical, dated			scheduled shower times weekly.	
	8/20/11, from a	local hospital (hospital			Unit managers will validate weekly	
	1), indicated the	resident had a past			skin assessment accuracy through	
	medical history of	of Quadriplegia after a			random audits of a total of 5	
	neck injury, Stati	us post supra pubic			observations weekly.	
	catheter in 1980.	Sacral decubitus ulcer,				
		and Debridement of a				
	sacral decubitus					
	Sucrai accuoitas	in the past.				
	Review of another	er History and Physical,				
		al hospital (hospital 2),				
		1, indicated the resident				
		hospital 1 on 8/19/11				
		-				
		turia and urosepsis,				
		ration and had septic				
		respiratory failure from				
	_	ad a tracheostomy. The				
	resident was tran	sferred to hospital 2 on				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155446	B. WIN			12/21/2011
CE OF P				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	L		5700 W	ILKIE DR	
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	NTER	FORT V	VAYNE, IN 46804	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	· 1	tinued antibiotics and				
		d not been able to eat and				
	was fed through a Gastrostomy tube.					
	A nursing admis	sion assessment, dated				
	11/7/11, indicate	ed the resident had a				
	history of pressu	re ulcers, and was				
	assessed to have	a scar on the coccyx, and				
		area on the right toe, but				
		nditions. The initial skin				
	interventions list	ed included pressure				
		s, repositioning program,				
	_	e management. The				
		revealed the resident had				
		ee and a Gastrostomy				
	tube.	c and a Gastrostomy				
	tube.					
		dated 11/7/11 at 4:45				
	p.m., indicated the	ne resident was admitted				
	with a tracheosto	omy, peg tube and was to				
	get Pivot 50 cubi	ic centimeters (cc) an				
	hour from 8:00 p	o.m., to 6:00 a.m., had a				
	catheter, and was	s on a mechanical soft				
	diet.					
	A nutrition scree	ning and assessment,				
		indicated the resident				
	· ·	supplement, Pivot, at 50				
		and skin was intact.				
	A Braden scale a					
		re sore risk, indicated				
		e completed on 11/7/11,				
		1/28/11, and indicated				
		ed "9" with a total score				
	me resident score	eu 9 with a total score]

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155446	B. WIN	G		12/21/	2011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ILKIE DR		
COVING	TON MANOR HEAL	LTH AND REHABILITATION CEN	ITER	FORT V	VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	•	resenting a high risk for					
	pressure sore.						
	-	evaluation record, dated					
	11/26/11, indica						
		e 2 pressure ulcer on the					
	1 –	easuring 2.0 centimeters					
	(cm) by 2.0 cm,	no odor, scant serous					
	drainage, non-gra	anulating, and intact					
	surrounding skin	l.					
	A reassessment,	completed on 11/28/11,					
	indicated the san	ne assessment					
	information as w	as documented on					
	11/26/11.						
	A nursing note,	dated 11/29/11,					
	indicated the resi	ident was started on an					
	antibiotic Intrave	enously, for 10 days, due					
	to an abnormal u	rinalysis, but there was					
	no further docum	nentation in the nursing					
		he pressure ulcer on the					
	1	ks, until a nursing note,					
		, at 9:00 a.m., indicated					
		l was 50 percent slough					
		tissue with a medium					
		y drainage, and had a					
		gns or symptoms of					
	infection.	- • •					
	A nursing note, of	dated 12/4/11, at 9:00					
		ne resident continued to					
	1	on the sacrum dressing					
		ed, and the wound was 50					
		nd granulation tissue,					
	r 2.200 Sio agri di	6-minimum 1150me,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155446	B. WIN			12/21/2011
NAME OF D	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	-		5700 W	ILKIE DR	
		TH AND REHABILITATION CEN	ITER	FORT V	VAYNE, IN 46804	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	BEIGERET	DATE
		as actively bleeding and				
		e a slight odor, with				
	_	ached, and no signs or				
	symptoms of info	ection.				
	Review of the ulcer evaluation record,					
	dated 12/4/11, in	ndicated the wound				
	measured 7.0 cm	by 6.0 cm, had an odor,				
	with moderate sa	nguineous drainage, 50				
	percent slough,	pink surrounding skin,				
	and was unstages					
	A physician's ord	ler, dated 12/4/11,				
	indicated the Vas	solex to the buttocks was				
	to be discontinue	ed, and a new order to				
		m ulcer and apply				
		ield sacrum patch on				
	12/4/11, and cha	-				
		Fridays. The orders also				
	1	n C 500 milligrams twice				
	a day for 30 days	· ·				
		y day for 30 days, to				
		nealing, and a referral to				
	the Wound Clini					
		in order, dated 12/4/11,				
		ot tube feeding was				
		d the resident was to be				
	started on Diabet					
	Started on Diauci					
	A change in cond	dition report, dated				
	12/4/11, at 11:00	p.m., indicated the				
	resident was sent	to the emergency room				
	due to inability to	get adequate air				
	1	h his tracheostomy.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155446	B. WIN	G		12/21/2	2011
NAME OF P	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					ILKIE DR		
COVING	TON MANOR HEA	LTH AND REHABILITATION CEI	NTER	FORT V	VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		dated 12/5/11, at 2:00					
	a.m., indicated the resident had returned from the hospital, with a new tracheostomy. A nursing note, dated 12/7/11, at 4:00						
		·					
	-	he resident was informed					
		d recommended treatment					
	at the wound clinic. The note indicated						
		sed the appointment due					
	-	the area on his buttocks					
	opening from time to time. The resident						
	-	new his body and knew					
		will say, so he would					
	` ′	ike he has in the past, and					
	_	(with) wound clinic if					
		does what the doctor has					
	ordered in the pa	ast."					
ı	Cara plans data	ed 11/11/11, indicated a					
		paired skin integrity					
	_	iplegia, impaired					
	_	inence, pain, and history					
	of breakdown.	moneo, pam, and motory					
		cluded, but not limited to:					
		g mattress to bed,					
	^	g cushion to wheelchair,					
	_	egrity during am/pm care,					
		istered dietician) as					
	` `	ate diet/needs, evaluate					
		I low loss air mattress.					
	SKIII WCCKIY, AIIC	i iow ioss an matticss.					
	Review of the tro	eatment sheet for					
		, indicated weekly skin					
	1 10 10111001, 2011	, maiouca wookiy skiii	ı				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155446	B. WIN			12/21/	2011
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
COVING	TON MANOR HEA	LTH AND REHABILITATION CEI	NTER		'ILKIE DR VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DD CAME DATE OF THE COMMON		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		e to be completed with a					
	narrative. An ac	lmission assessment, was					
	completed on 11/7/11, however, there						
	were blanks und	er the marked off dates					
	for 11/14/11, 11	/21/11, and 11/28/11 on					
	the treatment she	eet.					
	A nutrition scree	ening and assessment,					
		indicated the skin was					
	intact.						
		utritional progress note,					
	dated 12/2/11, was documented by the						
	· ·	, and indicated the					
		a mechanical soft diet,					
		vas 210 pounds, and Pivot					
	_	tube feeding. There was					
		or interventions on the					
	1	ing the development of					
	the pressure sore	•					
	A discharge inst	ruction sheet, dated					
	12/9/11, indicate	ed the resident was					
	discharged to ho	me with home health					
	care, and friends	were to provide 24 hour					
	care.						
	A skin Condition	n report, dated 12/9/11,					
	on discharge, in	dicated the resident had					
	sacral wounds w	with buttocks excoriation,					
	stage 2, on the co	occyx/sacrum.					
	The DNS was in	terviewed, at 2:35 p.m.,					
		d indicated the resident					
		open areas when he was					
	-	ad a history of pressure					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE (COMPL		
ANDILAN	or connection	155446		LDING	00	12/21/	
		100440	B. WIN		A DDDDGG GUTY GTATE TID GODE	12/21/	2011
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
COVING	TON MANOR HEAI	LTH AND REHABILITATION CEN	ITFR		VAYNE, IN 46804		
					I		(V.5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		ated because the resident					
		pressure sores, he was					
		loss alternating air					
	_	essure cushion placed in					
	his wheelchair,	_					
	ms wheelenan,	on warmooron.					
	The Rehab Nurs	e Manager, was					
		12/19/11, at 2:49 p.m.,					
	•	e resident was "pretty					
		transferred using the					
	•	Physical, Occupational,					
		apies, and had a feeding					
	_	n, but also ate food by					
		o indicated the resident					
		ented, and made his own					
	health care decis						
	The wound nurse	e was interviewed on					
		p.m., and indicated the					
		her he had a history of a					
		ttocks, that would close					
		e indicated the initial					
	_	ent had identified a "scar"					
	_	coccyx area. She					
		ge 2 pressure ulcer which					
	· `	/26/11, was close to the					
	_	d she did not see scars					
		n the resident. She					
	1 -	rses did weekly skin					
		he residents, and once a					
		as identified, she did					
		ents and measured the					
		cated between her weekly					
		e floor nurses did the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE : COMPL		
ANDILAN	OF CORRECTION	155446	A. BUI	LDING	00	12/21/	
		133440	B. WIN			12/21/	2011
NAME OF F	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
COMPIC		TH AND REHABILITATION CEN	TED		'ILKIE DR VAYNE, IN 46804		
			IEK	<u> </u>	VATNE, IN 40004		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		ssessed the wounds.		TAG	Dia feliate 1)		DATE
		e indicated she did the					
		1/26/11 for the stage 2					
	-	ecause she was on call					
	· ·	nd then reassessed the					
		, her routine day for					
	doing the wound						
	She indicated she						
	•	/4/11, and reassessed the					
		easured 7.0 cm by 6 cm,					
	_	able. She indicated this					
		ound which was identified					
		sure ulcer on 11/26 and					
		d now become a larger					
	area. She indica	ted when she assessed the					
	area on 12/4/11,	it was 50 percent slough,					
	so was unstageat	ole.					
	The wound nurse	e indicated she talked to					
	the resident abou	it going to the wound					
	clinic to make su	re he had the					
	appointment ava	ilable before he was					
	discharged from	the facility, but the					
	resident refused	because he indicated he					
	had the same this	ng before and knew the					
	physician would	just "slap yellow stuff"					
		d he would just have to					
	sit and wait at the	_					
	The wound nurse	e indicated the resident					
	had a low loss ai	r mattress in place, and					
		ecked the inflation in the					
		ake sure there were					
	proper prevention						
	rr proventio	F					
	The DNS was in	terviewed at 4:00 p.m.,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED
		155446	B. WI			12/21/2011
NAME OF D	PROVIDER OR SUPPLIER	•	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-
					ILKIE DR	
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	ITER	FORT V	VAYNE, IN 46804	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	, , , , , , , , , , , , , , , , , , ,	d indicated the initial skin				
		esident B was completed				
	on 11/7/11 when the resident was admitted, but none of the other weekly					
		had been completed.				
		ed a corporate nurse had				
		11, and identified a				
		weekly skin assessments				
	on some of the re	esidents had not been				
	completed, and	Resident B was one of				
	the residents iden	ntified.				
	The DNS indicat	ed the facility policy to				
	turn the resident	every 2 hours was				
	followed and a lo	ow loss alternating				
	pressure mattress	s offloaded pressure				
	every 10 minutes	s was used.				
	The DNS was in	terviewed on 12/20/11,				
	at 9:03 a.m., and	indicated there were no				
	additional dietary	y progress notes				
	documented, and	d the Dietary Manager				
	was no longer en	nployed at the facility and				
	_	ith her last day worked on				
	_	NS indicated she had				
	done an audit of	the dietary progress notes				
		15/11, and found the				
		be out of compliance.				
		F				
	The DNS was in	terviewed at 10:45 a.m.,				
		indicated the nurses				
	· ·	he Medicare skilled flow				
		pasis, on the rehab unit,				
	· ·	there was not an area to				
	_					
	uocument skin as	ssessments, it would be				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155446	B. WIN	IG		12/21/2011
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	
000,410.00	TON 144110D 11541	TIL 4ND DELLABILITATION OF	ITED		ILKIE DR	
COVING	TON MANOR HEAL	_TH AND REHABILITATION CEI	NIER	FORTV	VAYNE, IN 46804	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
TAG		<u> </u>		IAU		DATE
	anything unusua	ses would document				
	She indicated the CNAs documented					
		l when showers were				
		dents, 2 times weekly,				
	1 -	ressing the residents, and				
		the nurses if anything				
	•	nd. She indicated the				
		ssessments on every				
		ekly basis, not just on				
		for pressure sores.				
		F				
	Review of the "E	Best Practice Skin				
	Integrity Process	" policy, provided by the				
	Director of Nurs	ing Services (DNS), at				
	10:00 a.m., on 12	2/20/11, indicated the				
	following:					
		nication by CNA to				
	licensed nurse ut	ilizing a skin condition				
	worksheet or cor	nparable document;				
	Documentation	on of the turning and				
	_	east every two (2) hours				
	while in bed or in					
		wer/bed bath schedule for				
		clude utilization of skin				
		neet by the CNA with				
	licensed nurse co	_				
	1	l to toe" assessment of all				
	I -	ensed nurses with				
		entation of findings;				
	Dietary support would include additional nutritional supplement or					
		ording to the Registered				
	Dietician's recon	nmendations;				

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-	OF CORRECTION	IDENTIFICATION NUMBER: 155446	UILDING 00 COMPLETED 12/21/2011			ETED
	PROVIDER OR SUPPLIER	TH AND REHABILITATION CENT	STREET A	ADDRESS, CITY, STATE, ZIP CODE ILKIE DR VAYNE, IN 46804		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) an as appropriate.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
	reviewed on 12/1 and indicated the to the facility on including, but no chronic kidney disease. The initial admis 10/20/11, indicastight rash in the bruise to the left pitting edema to extremities, left a left hip replaced. A Braden Scale apressure sore risk 10/27, 11/3, and the resident was sores. The treatment she indicated weekly completed on additional treatment she ets.	ecord of Resident D was 9/11, at 10:00 a.m., resident was readmitted 10/20/11, with diagnoses t limited to, diabetes, isease and coronary sion assessment, dated ted the resident had a abdominal folds, a upper/inner arm, 3+ the bilateral lower anticubital bruising, and ment incision. Assessment for predicting a was completed on 11/10/11, and indicated not at risk for pressure seet for October, 2011, skin assessments were mission and again on for November, 2011, skin assessments were				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) E			(X3) DATE	DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	A. BUILDING 00 COMPLETED					
155446			B. WING 12/21/2011					
NAME OF PROVIDER OR SUPPLIER			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
				5700 WILKIE DR				
COVING	TON MANOR HEA	LTH AND REHABILITATION CEN	ITER	FORTV	VAYNE, IN 46804			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	· ·	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE	
TAG		dated 10/30/11, at 12	+	TAG			DATE	
		the physician was notified						
	1	ent having 3+edema, and						
		e left for Bumex to be						
		l lab ordered for 11/1/11.						
	•	o indicated she just felt						
	bad.	5 material she just left						
	vau.							
	Δ nurging note	dated 10/31/11, at 10:50						
		"dark purple dti (deep						
	tissue injury) noted to l (left) foot, lateral							
	arch area. Dry calloused skin surrounding.							
	Res (resident) c/o(complained of) mild							
	pain sensation upon exam or pressure c							
	(with) foot weight bearing. Edemas 3+							
	pitting continues bilat (bilateral) LE							
	(lower extremities). "							
	The Pressure Ulcer Evaluation Form,							
	dated 10/30/11, indicated the resident had							
	a deep tissue injury on the left foot, which							
	measured 3 centimeters(cm) in length							
	and 1.5 cm in width with no drainage.							
	A change of condition report, dated							
	10/30/11, indicated the physician was							
	contacted on 10/30/11 at 12 noon,							
	regarding the new area, but left no new							
	orders.							
	The Pressure Evaluation Form indicated a							
	deep tissue injury is defined as "Purple							
	or maroon localized area of discolored							
	intact skin or blood- filled blister due to							
	damage of underlying soft tissue from pressure and/or sheer"							
	1	****					ı	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
155446		B. WING 12/21/2011					
VALUE OF DE CAMPE DE CAMPE DE				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER			5700 WILKIE DR				
		TH AND REHABILITATION CEN	ITER	FORT V	VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE	DATE	
	_	evaluation form, dated					
	-	ted an unstageable area to					
		, measuring 1.2 cm by					
	2.5 cm, which w	as 100 percent eschar,					
	and pink surroun	ding skin with swelling.					
	D1 · · · 1	1 , 111/1/11					
	Physician orders	· · · · · · · · · · · · · · · · · · ·					
		he left lateral foot arch					
		ninal pad and fix with					
	loose kerlix, change daily and as needed						
	for loosening/soilage.						
	Also a venous doppler study was ordered						
	to the bilateral lower extremities, for						
	swelling and pain to rule out deep vein						
	thrombosis.						
	Another physician order, dated 11/1/11,						
	1	al extremity compression					
		hatic massage was					
	ordered due to ed	_					
	ordered due to edema.						
	A bilateral lower extremity venous ultrasound test, dated 11/2/11, indicated no evidence of deep vein thrombosis involving the lower extremities bilaterally.						
	onactally.						
	A pressure ulcer evaluation, dated 11/7/11, indicated the area was						
	unstageable, 100 percent eschar, and						
	_	_					
	measured 1.1 cm by 3.0 cm. An occupational therapy daily treatment note, dated 11/16/11, indicated resident						
	· ·	on 11/15/11, and the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
155446		B. WING 12/21/2011					
VALUE OF DE OVERER OF GUIDNIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER			5700 WILKIE DR				
COVINGTON MANOR HEALTH AND REHABILITATION CENT			ITER	FORT V	VAYNE, IN 46804		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)	DATE	
	therapist was wit	•					
	•	ps due to the abnormal					
	lab results.						
	A physical therap	by progress report, dated					
	11/18/11, indicat	ed the open area to the					
	left foot was imp	roving, but now noted a					
	small pressure ar	ea laterally to the right					
	foot, and nursing	was notified.					
	٠						
	A narrative nursing note, dated 11/18/11,						
	at 11:15 a.m., indicated a new wound						
	sheet was completed for a small, dry,						
	deep tissue injury to the lateral side of the						
		ring 2 cm by 2 cm.					
	_	_					
	_	evaluation form, dated					
	-	ed there was a deep					
		ne right foot, lateral side,					
	_	by 2 cm, no odors, no					
	drainage, epithelialization, hard/scarred wound edges, and pink surrounding skin. A pressure ulcer evaluation form, dated 11/21/11, indicated the area on the right						
	foot was unstageable, measured 0.5 by 0.8						
	-	rainage, 100 percent					
		lges defined, and the					
	surrounding skin	was pink.					
	A pressure ulcer evaluation, dated 12/12/11, indicated the area was healed						
	-	ted the area was nealed					
	to the right foot.						
	On 11/22/11 the	resident was transferred					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			X2) MULTIPLE CONSTRUCTION A. BUILDING 00		COMP	(X3) DATE SURVEY COMPLETED	
155446		B. WIN	IG		12/21	/2011	
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENT			STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR ENTER FORT WAYNE, IN 46804				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	to the hospital for a scheduled blood transfusion.						
	A pressure ulcer evaluation, dated 12/19/11, indicated the area located on the left foot arch measured length was 0.8 centimeters (cm) and 1.8 cm.						
	On 12/20/11 at 12:15 p.m. the LPN Wound Nurse was interviewed in regard to the cause of the pressure ulcers and she indicated she thought the pressure ulcers developed due to the resident had cellulitis and edema.						
	Occupational The was interviewed compression wrates resident wore the 23 hours a day 7 COTA further in wraps through the applied the wraps both nursing and for assessing the	2:45 p.m. the Certified erapy Assistant (COTA) in regard to the ps and indicted the compression wraps for days a week. The dicated she applied the e week and Nursing s on the week-ends and COTA were responsible residents bilateral legs were removed for 1 hour					
	Nursing Service in regard to the re and she indicated	:55 p.m. the Director (DNS) was interviewed esident's pressure ulcer If the resident only wore after the first pressure					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		A. BUILDING 00 COMPLETED 12/21/201						
133440			B. WIN		A PARAGO CITIL CONT. TIP CONT.	12/21/	2011	
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE			
COVING	TON MANOR HEA	LTH AND REHABILITATION CE	5700 WILKIE DR ENTER FORT WAYNE, IN 46804					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
	1	. The DNS further						
		sident had a special on mattress with a "heel						
	slope"	on mattress with a neer						
	Slope							
	On 12/21/11 at 1	10:45 a.m. an observation						
	of the resident's	pressure area with RN #3						
		the left foot arch and the						
		pink and surrounding						
	tissue were pink and slightly swollen with							
	a scant amount of serosanguineous							
	drainage on the	old dressing.						
	This federal tag relates to complaint IN00101272							
	3.1-40(a)(1) 3.1-40(a)(2)							

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